



Patient Referral/Medication Request - Infertility

Aetna Specialty Pharmacy®
 503 Sunport Lane
 Orlando, FL 32809
Phone: 1-866-782-2779 (1-866-782-ASRX)
FAX: 1-866-329-2779 (1-866-FAX-ASRX)

Today's Date: _____ Anticipated Start Date: _____

PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office			

INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:

Secondary Insurance:

Policy #:	Group #:	Insured:	Phone:
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PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	Zip:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

DIAGNOSIS:

Primary:	ICD 9:	Secondary:	ICD 9:
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PRESCRIPTION (Please select from below and provide approximate days supply.)

<input type="checkbox"/> Bravelle # of Refills _____ 75 IU Vial # of Vials _____ Sig: _____ <input type="checkbox"/> Follistim AQ # of Refills _____ <input type="checkbox"/> 300 IU # of Cart. _____ <input type="checkbox"/> Follistim Pen # of Cart. _____ <input type="checkbox"/> 600 IU # of Cart. _____ <input type="checkbox"/> AQ Vial 75 IU # of Cart. _____ <input type="checkbox"/> 900 IU # of Cart. _____ <input type="checkbox"/> AQ Vial 150 IU # of Cart. _____ Sig: _____ <input type="checkbox"/> Gonal F® RFF # of Refills _____ <input type="checkbox"/> 300 IU Pen _____ Each <input type="checkbox"/> 75 IU Vial _____ Vials _____ <input type="checkbox"/> 450 IU Pen _____ Each <input type="checkbox"/> MDU 450 IU _____ Vials _____ <input type="checkbox"/> 900 IU Pen _____ Each Sig: _____ <input type="checkbox"/> Repronex® # of Refills _____ 75 IU Vials _____ Vials Sig: _____ <input type="checkbox"/> Leuprolide® # of Refills _____ 2 Week Kit _____ Kit Sig: _____ <input type="checkbox"/> Ganirelix Acetate # of Refills _____ 250mg/0.5ml _____ PFS Sig: _____ <input type="checkbox"/> Cetrotide # of Refills _____ <input type="checkbox"/> 0.25mg <input type="checkbox"/> 3mg _____ PFS Sig: _____ <input type="checkbox"/> Ovidrel # of Refills _____ 250mcg _____ PFS Sig: _____ <input type="checkbox"/> Menopur # of Refills _____ 75 IU _____ Vials Sig: _____ <input type="checkbox"/> Crinone 8% Gel (18 per box) # of Refills _____ _____ Boxes Sig: _____ <input type="checkbox"/> Vivelle™ Dot (8 per box) # of Refills _____ <input type="checkbox"/> 0.05mg <input type="checkbox"/> 0.1mg _____ Boxes Sig: _____ <input type="checkbox"/> Progesterone in Sesame Oil # of Refills _____ 50mg/ml 10ml Vial _____ Vials Sig: _____ <input type="checkbox"/> Estradiol # of Refills _____ <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg _____ Tabs Sig: _____ Please note: When ordering more than a quantity of 30 Estradiol tabs, please call 1-800-414-2386 for a max dose override.	<input type="checkbox"/> Medrol® # of Refills _____ <input type="checkbox"/> 4mg <input type="checkbox"/> 16mg _____ Tabs Sig: _____ <input type="checkbox"/> Novarel/HCG 10,000 IU or <input type="checkbox"/> Generic HCG 10,000 IU # of Refills _____ _____ Vials Sig: _____ <input type="checkbox"/> Prometrium # of Refills _____ <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg _____ Tabs Sig: _____ <input type="checkbox"/> Other # of Refills _____ _____ To be dispensed _____ To be dispensed Sig: _____ COMPOUND MEDICATIONS (May take 24 – 48 hours) <input type="checkbox"/> HCG low dose # of Refills _____ _____ Units/_ml Sig: _____ <input type="checkbox"/> Lupron Microdose # of Refills _____ _____ mcg/0.1ml _____ 5ml _____ mcg/0.2ml _____ 5ml Sig: _____ <input type="checkbox"/> Progesterone Vaginal Supp. # of Refills _____ <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> 400mg _____ Supp. Sig: _____ <input type="checkbox"/> Progesterone Vaginal Cap # of Refills _____ <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg _____ Caps Sig: _____ <input type="checkbox"/> Progesterone Oral Cap # of Refills _____ <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg _____ Caps Sig: _____ <input type="checkbox"/> Progesterone in _____ Oil # of Refills _____ <input type="checkbox"/> 50mg/ml _____ Vials Sig: _____ SUPPLIES <input type="checkbox"/> 22g 1 1/2" 3 cc needle # _____ <input type="checkbox"/> 30g 1/2" needle # _____ <input type="checkbox"/> 18g 1" needle # _____ <input type="checkbox"/> 20g 1" needle # _____ <input type="checkbox"/> 27g 1/2" needle # _____ <input type="checkbox"/> 3 cc syringe # _____ <input type="checkbox"/> BD Microfine Pen Needle 29G 1/2" # _____ <input type="checkbox"/> Insulin Syringes 1/2 cc # _____ <input type="checkbox"/> Other Syringes Size _____ # _____ <input type="checkbox"/> Other Syringes Size _____ # _____
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Prescriber's Signature Required by Law: _____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space.